City of Hope | LABORATORIES

ROUTINE REQUISITION FORM

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SEND TO:	City of Hope National Medical Center - ATTENTION: LAB OUTREACH DEPT 1500 E. Duarte Road Main Medical 2nd Floor Room 2101 Duarte, CA 91010 TOLL FREE: 1(844) 313-5227 (LABS) | FAX: 1(626) 218-0736 | EMAIL: laboutreach@coh.org

CLIENT INFORMATION		ORDERING PHYSICIAN	
CLIENT NAME		NAME	
ADDRESS 1		NPI	
ADDRESS 2		TEL	FAX
CITY		COPY TO PHYSICIAN	
STATE	POSTAL CODE	NAME	
COUNTRY		NPI	
TEL	FAX	TEL	FAX

PATIENT INFORMATION (May use patient identification label)					
LAST NAME	FIRST NAME				PATIENT ID
STREET ADDRESS			CITY		
STATE	POSTAL CODE			COUNTRY	
DATE OF BIRTH (MM/DD/YYYY)	AGE	SEX ☐ M ☐ F	MARITAL STATUS		PRIMARY PHONE #

BILLING INFORMATION

SEE ATTACHED ☐ INSURANCE CARD (Front and Back) + PATIENT DEMOGRAPHICS

☐ INSTITUTION/CLIENT ☐ PPO INSURANCE ☐ MEDICARE ☐ MEDICAL/MEDICAID ☐ PATIENT/SELF PAY

POLICY SUBSCRIBER *Required for minors and if other than patient*

NAME DATE OF BIRTH (MM/DD/YYYY)

☐ HMO _____

****Authorization Number Required prior to testing ****

CLINICAL INFORMATION / PROCEDURE NOTES REQUIRED			ICD-10 DIAGNOSIS CODES	
SUSPECT DIAGNOSIS, PERTINENT LAB DATA			MUST BE PROVIDED FOR EACH TEST	
SPECIMEN ID	COLLECTION DATE	COLLECTION TIME	COLLECTED BY	

REQUIREMENTS TO SUBMIT

OUTSIDE SLIDE REVIEW REQUEST

1. Copies of all surgical pathology reports related to the diagnostic specimen
2. Clinical History
3. All stained slides (including immunostains)
4. A representative paraffin block or 15 unstained sections on charged slides

SERVICES REQUESTED

☐	**PROFESSIONAL CONSULT (SLIDES ONLY)**	**# Slides:**	**# USS**	
☐	**PROFESSIONAL CONSULT WITH IHC (SLIDES & BLOCKS)** Call for approval of special testing	**# Slides:**	**# USS**	**# BLOCKS**
☐	**COMPREHENSIVE CONSULTATION (SLIDES & BLOCKS)** IHC & special testing at discretion of consultant	**# Slides:**	**# USS**	**# BLOCKS**
☐	**OTHER TESTING:**			

I authorize the above laboratory test(s). I understand as the practitioner, it is my responsibility for determining the medical necessity of the laboratory tests.

PHYSICIAN SIGNATURE x_____ **DATE** _____

City of Hope National Medical Center relies upon the accuracy of the above information as provided by Institution in the rendering of services under the Agreement. Institution will provide prompt written notification of any changes to City of Hope.